DISTRICT OF COLUMBIA
OFFICE OF ADMINISTRATIVE HEARINGS
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Washington, DC 20002-4210

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH Petitioner, v. EARLINE POLLOCK-LEE Respondent	Case No.: DH-C-07-800079

FINAL ORDER

I. Introduction

On January 26, 2007, the District of Columbia Department of Health, Health Regulation Administration (the "Government"), issued a Notice of Proposed License Denial to Respondent Earlene Pollock-Lee[1] to deny Respondent's license renewal for a Community Residence Facility known as the Pollock House, located at 915 Farragut Street, N.W. (the "CRF"). The proposed action was based on three charges: an alleged violation of The Clean Hands Before Receiving a License or Permit Act of 1966, D. C. Official Code § 47-2862(a)(3) (the "Clean Hands Act"); and two (2) alleged violations of the District of Columbia Municipal Regulations ("DCMR") pertaining to operating standards for CRFs, one based on 22 DCMR 3404.3 (failure to secure immediate medical care for a seriously ill resident), and the second based on 22 DCMR 3406.1 (failure to provide a secure and protective environment for each resident).

[1] Respondent corrected the misspelling of her first name, and the caption has been changed accordingly. See also Respondent's Exhibit ("RX") 118 (License for Community Residence Facility issued to Earline M. Pollock-Lee).

On February 16, 2007, Respondent filed a request for a hearing pursuant to D.C. Official Code § 47-2865(a) and 22 DCMR 3107.2.[2] Subsequently, Respondent's motion to postpone the hearing scheduled for March 30, 2007, was granted, and the hearing was held on April 30, 2007.

At the hearing, Respondent appeared and represented herself. Carmen Johnson, Assistant Attorney General, appeared on behalf of the Government.

In accordance with the post-hearing briefing schedule agreed to at the conclusion of the hearing, on May 15, 2007, the Government filed its Findings of Facts and Conclusions of Law. In a letter filed on June 15, 2007, Orlando D. Barnes, Esquire, entered his appearance on behalf of Respondent, and on the same date Mr. Barnes filed Respondent's Reply to the Government's submission and Respondent's Findings of Facts and Conclusions of Law.

On June 29, 2007, the Government filed a letter objecting to Mr. Barnes' entry of appearance on behalf of Respondent on the ground that it was untimely because it was not within ten (10) days of the scheduled hearing, as provided in the Case Management Order. The Government moved to "deny acceptance" of the submissions prepared by Mr. Barnes, which I construe as a motion to have Respondent's post-hearing submissions rejected or stricken on the ground that Mr. Barnes' appearance on behalf of Respondent was untimely.

I will deny the Government's motion. Respondent was not precluded by the Case Management Order from having an attorney advise her and represent her in connection with

[2] On March 7, 2007, the Government issued to Respondent a Notice of License Denial regarding her CRF license. The stated basis for this action was Respondent's alleged failure to request a hearing on the Notice of Proposed Denial issued on January 26, 2007. RX 112. The Notice of License Denial was obviously issued in error, since Respondent had requested a hearing and the Case Management Order in this case was issued prior to the issuance of the Notice of License Denial. The Government has not relied on the Notice of License Denial in this proceeding.

post-hearing proceedings or submissions. The Case Management Order required that a party who wished to be represented by an attorney at the hearing have the attorney enter his or her appearance at least ten (10) days before the hearing.

Based upon the testimony of the witnesses, my evaluation of their credibility, the documents admitted into evidence, the parties' post-hearing submissions, and the entire record in this matter, I now make the following findings of fact and conclusions of law.

II. Findings of Fact

At all times relevant, Respondent was the Residence Director and licensee of the CRF. RX 118. Respondent is a nurse, and she was employed full-time by St. Thomas More, a non-medical health care facility in Hyattsville, Maryland. Although Respondent was the Residence Director of the CRF, she went there only on some evenings and on some weekends. The CRF's House Manager was Reginald Pollock. Petitioner's Exhibit ("PX") 203.

In 2005 the Government received several complaints about the CRF concerning the quality of care provided to its residents, and also about alleged misappropriation of residents' funds. PX 200. In June 2005, the Government, through Hilda Goldberg, a social worker with the District of Columbia Department of Health, Health Regulation Administration, conducted an investigation and, after reviewing the records of the CRF, Ms. Goldberg determined that the CRF had failed to maintain financial records for one of the residents, Frederick ("Freddie") Martin.

By Notice of Infraction No. D100086 (the "NOI") served on September 20, 2005, Respondent was charged with a violation 22 DCMR 3407.5 (failure to maintain separate and accurate records of residents' funds and property). After a hearing before an Administrative Law

Judge in the Office of Administrative Hearings ("OAH") on March 3, 2006, Respondent was found liable for the violation, and a fine of $500 was imposed. *District of Columbia Department of Health v. Pollock House & Earline M. Lee*, OAH No. DH-I-05-D100086 (Final Order, Mar. 30, 2006). PX 117. Respondent paid the fine by her personal check dated April 2, 2006, payable to the D.C. Treasurer. RX 113. The check did not refer to the pertinent NOI, but referred only to "DCRA Fine." Accordingly, the check was not recorded in the records of OAH as a payment for the fine in Case No. DH-I-05-D100086. In the course of the proceedings in the instant case, this error was corrected, and a Notice of Payment of the fine was issued on August 2, 2007, closing out Case No. DH-I-05-D100086.[3]

The charges against Respondent pertaining to her alleged failure to meet operating standards for the CRF also relate to Mr. Martin: namely, the alleged failure to secure immediate medical care for him when he was seriously ill and to provide a secure and protective environment for him.

Mr. Martin was about 68 years old when he began to reside in the CRF. Over the years he had resided in several different group homes. PX 203. Apparently he did not have any living immediate family or any close friends, and he rarely interacted with others. One of the other residents at the CRF reported, however, that she appreciated Mr. Martin's "quiet and pleasant nature and enjoyed living with him." *Id.* It appears that Mr. Martin preferred to be alone and that he never complained. *Id.*

Respondent obtained letters from three people who were acquainted with Mr. Martin who stated that when each saw him he appeared cordial, well-mannered, and neat. None of these

[3] This administrative court takes official notice of the records in its own cases.

individuals testified at the hearing, and the extent of their interaction with Mr. Martin is either unknown or at best minimal, and it is not apparent what the pertinent time periods were.[4]

Beginning in June 2005, while he was a resident of the CRF, Mr. Martin began attending a day program five (5) days a week offered by Downtown Clusters Geriatric Day Care Center, Inc (the "Day Program"). PX 203. In and around September 2005, Margaret Mitchell, a registered nurse at the Day Program, contacted the CRF's House Manager, Reginald Pollock, multiple times about Mr. Martin's failing health, including several occurrences of bleeding from the mouth, and his habitually wearing soiled or dirty clothes.

As a result of Ms. Mitchell's complaints, on September 28, 2005, the CRF's House Manager finally brought Mr. Martin to a doctor, Keia Clay, M.D., who referred him to Dr. Sadeghi for an evaluation. Dr. Sadeghi saw Mr. Martin on October 5, 2005. His diagnosis was that Mr. Martin had cancer of the mouth and recommended further tests, including an MRI and a biopsy. RX 104 - 106. Dr. Sadeghi noted that Mr. Martin had been loosing weight and had a loss of appetite during the previous month and a half. RX 104.

After Mr. Martin was diagnosed with cancer of the mouth, neither Respondent nor anyone else on behalf of the CRF notified the Day Program of his condition or of any special needs his condition warranted. Also, Respondent did not seek a level of care determination to establish whether a new plan of care was warranted for Mr. Martin, or whether care should be provided by a facility offering care that was more skilled than that provided by the CRF.

[4] Sean Chen stated he saw Mr. Martin "on several occasions." RX 100. Cornell Robinson stated that he lived in the neighborhood and passed Mr. Martin in the street. RX 101.Victoria Robinson stated she knew Mr. Martin for approximately one year and saw him when she visited relatives at the CRF. She did not state the time period when she visited the CRF. RX 102.

The record does not reflect that Mr. Martin received any further medical attention until November 9, 2005. On November 9, 2005, Mr. Martin was dropped off at the Day Program when he obviously was in need of immediate medical attention. He had urinated on himself, and he was bleeding from the mouth. PX 203. Ms. Mitchell, the nurse at the Day Program, called the CRF's House Manager and recommended that Mr. Martin be seen by a doctor immediately.

As a result of Ms. Mitchell contacting the CRF's House Manager, Mr. Martin was taken to the Emergency Department at Providence Hospital where his condition was stabilized. It was recommended that Mr. Martin receive follow-up treatment from his primary care doctor, Dr. Sadeghi. PX 107. Dr. Sadeghi referred Mr. Martin for additional tests or procedures. RX 108-110.

On January 3, 2006, after a three day holiday weekend, Mr. Martin was dropped off at the Day Program, and again he was obviously seriously ill and in need of immediate medical attention. He looked gaunt and was disoriented. His clothes were stained with blood and food, and he was bleeding from his mouth. RX 203. The House Manager for the CRF was contacted and was urged to seek immediate medical attention for Mr. Martin, and to speak with a hospital social worker if the House Manager could not adequately care for Mr. Martin in the CRF.

The House Manager picked up Mr. Martin from the Day Program and simply dropped him off at the George Washington University Hospital and left him there all alone. Because of Mr. Martin's condition, he was not able to effectively communicate with the staff at the hospital, which made it difficult for the hospital to provide care for him. Eventually, Mr. Martin was admitted to the hospital. His cancer rapidly advanced, and on January 9, 2006, he died.

Immediately following Mr. Martin's death, Ms. Shriener, the social worker at the Day Program, furnished Respondent with information regarding burial assistance programs provided by the Department of Health and Human Services, Catholic Charities, and the Salvation Army. Respondent did not follow through with any funeral arrangements and refused to use Mr. Martin's January Social Security check to cover his funeral costs. RX 203

On January 3, 2006, Ms. Shriener also made a complaint to the Government about the lack of care given to Mr. Martin by Respondent and the CRF, and Ms. Goldberg conducted an investigation. Ms. Goldberg recommended enforcement action against Respondent based on occurrences of lack of quality of care for residents of the CRF, including Mr. Martin. RX 200.

III. Conclusions of Law

The Government may refuse to renew a license for a CRF if the applicant is in violation of the Clean Hands Act, and also for, among other reasons, the violation of any of the laws and regulations of the District of Columbia or United States relating to the operation of a CRF in the District of Columbia. *See,* 22 DCMR 3107. The Government denied Respondent's renewal of her license on the following three grounds or charges:

A. Alleged Violation of the Clean Hands Act.

D.C. Official Code § 47-2862(a)(3) provides:

> (a) Notwithstanding any other provision of law, the District government shall not issue or reissue any license or permit to any applicant for a license or permit if the applicant owes more than $100 in outstanding debt to the District as a result of . . . (3) Fines, penalties, or interest assessed pursuant to Chapter 18 of Title 2.

The Government alleged that Respondent failed to pay the $500 fine ordered by OAH in the case of *Department of Health v. Pollock House, supra*, OAH No. I-05-D100084. Respondent paid this fine in a timely manner, however, but because she did not indicate the matter to which the payment should be applied it was not recorded in the records of OAH on the file in question. In the course of the proceedings in the instant case, this error was corrected, and a Notice of Payment of the fine was issued on August 2, 2007, closing out Case No. DH-I-05-D100086.

Accordingly, the Government failed to sustain its burden of proof on this charge, and, and the Government may not deny Respondent's license renewal for a CRF based on the alleged violation of the Clean Hands Act.

B. Alleged Violation of 22 DCMR 3404.3

22 DCMR 3404.3 provides:

> In cases of serious illness or accident, medical care shall be secured immediately by the resident, if he or she is able, or by the Residence Director who shall first attempt to notify the resident's physician.

It is undisputed that at least as of September 2005 Mr. Martin had a serious medical condition. Ms. Mitchell, the nurse at the Day Program, had on several occasions expressed her concerns about Mr. Martin's discernibly poor health, including his bleeding from the mouth, and his poor personal hygiene. Although these conditions were known, or should have been known, by Respondent if she had conscientiously performed her duties as Residence Director, it was only as a result of the repeated complaints by the Day Program personnel that Mr. Martin was finally taken to a doctor on September 28, 2005. On this date Mr. Martin had been brought to the Day Program when he obviously needed immediate medical care.

On November 9, 2005, Mr. Martin was again seen by a doctor, and once again this occurred because of the intervention by the Day Program personnel. He had been dropped off at the Day Program when he obviously was in need of immediate medical attention. He had urinated on himself, and he was bleeding from the mouth. RX 203. Ms. Mitchell, the nurse at the Day Program, called the CRF's House Manager and recommended that Mr. Martin be seen by a doctor immediately. Mr. Martin was taken by the House Manager to the Emergency Department at Providence Hospital where his condition was stabilized.

On January 3, 2006, after a three day holiday weekend, Mr. Martin was dropped off at the Day Program, and once again he obviously was in need of immediate medical attention. He looked gaunt and appeared disoriented. His clothes were stained with blood and food, and he was bleeding from his mouth. RX 203. The House Manager for the CRF was contacted and was urged to seek immediate medical attention for Mr. Martin, and to speak with a hospital social worker if the House Manager could not adequately care for Mr. Martin in the CRF.

The House Manager picked up Mr. Martin from the Day Program and simply dropped Mr. Martin off at the George Washington University Hospital where he was left all alone. Because of Mr. Martin's condition, he was not able to effectively communicate with the staff at the hospital, which made it difficult to for the hospital to provide care for him. Mr. Martin was eventually admitted to the hospital, and his cancer rapidly advanced until he died on January 9, 2006.

The record reflects that on at least three instances Respondent failed to immediately secure medical care for Mr. Martin when he was seriously ill and not in a position to obtain

medical care on his own. Accordingly, the Government proved by the preponderance of the evidence that Respondent violated 22 DCMR 3404.3.

C. Alleged Violation of 22 DCMR 3406.1

22 DCMR 3406.1 provides:

> A supportative and protective environment shall be provided to each resident to promote his or her comfort, self-esteem, and personal dignity, and to ensure that the resident's property and civil rights are respected.

As Mr. Martin became increasingly ill due to his cancer of the mouth, he was unable to take care of himself, as evidenced by his inability to speak, to control his bodily functions, and to take care of his personal hygiene. Respondent, however, seemed oblivious to his condition, and failed to seek necessary medical attention, and failed to provide for him an environment that would ensure his comfort and personal dignity. I credit the testimony of the professional personnel at the Day program, Ms. Mitchell and Ms. Shriener, who observed Mr. Martin five days a week that his basic personal hygiene requirements were not being attended to at the CRF.

Respondent also failed to ensure that Mr. Martin's property was respected. Respondent was found liable for failing to maintain required financial records for him. *See Department of Health v. Pollock House*, *supra*, OAH No. I-05-D100084. And after Mr. Martin's death, Respondent did not make any funeral arrangements and refused to use his Social Security check to cover his funeral costs.

Accordingly, the Government proved by the preponderance of the evidence that Respondent violated 22 DCMR 3406.1 by failing to provide a supportative and protective

environment to Mr. Martin to promote his comfort, self-esteem, and personal dignity, and to ensure that his property and civil rights were respected.

Based on Respondent's violations of 22 DCMR 3404.3 (failure to secure immediate medical care for a seriously ill resident) and 22 DCMR 3406.1 (failure to provide a secure and protective environment for each resident), the Government may refuse to renew Respondent's license for a CRF, as proposed in the Notice of Proposed License Denial dated January 26, 2007.

IV. ORDER

Based upon the foregoing findings of fact and conclusions of law and the entire record in this matter, it is this 8th day of January, 2008:

ORDERED, that the Government's motion to have Respondent's post-hearing submissions rejected or stricken is hereby **DENIED**; and it is further

ORDERED, that the Government's **Proposed License Denial** dated January 26, 2007, denying Respondent's renewal of a license to operate a CRF is hereby **AFFIRMED;** and it is further

ORDERED, that the Government may **DENY RESPONDENT'S LICENSE RENEWAL FOR A CRF** as proposed in the Notice of Proposed License Denial dated January 26, 2007; and it is further

ORDERED, that the appeal rights of any person aggrieved by this Order are stated below.

/s/
Robert E. Sharkey
Administrative Law Judge